STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B105134	A. BUILDING: _____ B. WING _____	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HMONG ADULT HOME CARE	2617 69TH ST KANSAS CITY, KS 66109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citation represents the findings of a resurvey at the above named adult day care on 7-15-15 and 7-16-15.	S 000		
S2120 SS=F	26-43-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100;(3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-43-202(d) The facility reported a census of 3 residents. The sample included 3 residents. Based on record review and interview for 3 (#101, #102, #103) of 3 sampled residents, the operator failed to ensure the review and, if necessary, revision of each negotiated service agreement at least once every 365 days. Findings included: - Record review for resident #101 revealed	S2120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B105134	A. BUILDING: _____ B. WING _____	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HMONG ADULT HOME CARE	2617 69TH ST KANSAS CITY, KS 66109

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S2120	Continued From page 1	S2120		

admission on 9-19-11.
The Functional Capacity Screen dated 4-28-15 recorded resident required supervision with transfers; physical assistance with walking/mobility; and independent with bathing, dressing, toileting and eating. Continent of bladder. Cognition: problems with short term memory and memory/recall. Current problems/risks included unsteadiness. Uses cane.

The Negotiated Service Agreement (NSA) dated 4-1-13 recorded services for Nutrition (daily breakfast, lunch and snack) and assistance with personal hygiene. Facility to provide transportation and activities. The NSA lacked review and if necessary revision at least once every 365 days.

- Record review for resident #102 revealed admission on 8-28-12.
The Functional Capacity Screen dated 4-28-15 recorded resident independent with bathing, dressing, toileting, transfers, walking/mobility and eating; supervision with management of medications/treatments. Continent of bladder. Cognition: problems with memory/recall and decision-making. Current problems/risks included falls, impaired hearing, and impaired vision.

The Negotiated Service Agreement (NSA) dated 4-1-13 recorded services for Nutrition (daily breakfast, lunch and snack). Independent with Personal Care. Facility to provide transportation and activities. The NSA lacked review and if necessary revision at least once every 365 days.

- Record review for resident #103 revealed admission on 3-18-13.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B105134	A. BUILDING: _____ B. WING _____	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HMONG ADULT HOME CARE	2617 69TH ST KANSAS CITY, KS 66109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S2120	Continued From page 2 The Functional Capacity Screen dated 4-30-15 recorded resident independent with bathing, dressing, toileting, transfers, walking/mobility and eating; unable to perform management of medications; and supervision with treatments. Continent of bladder. Cognition: problems with memory/recall and decision-making. Current problems/risks included falls. The Negotiated Service Screen (NSA) dated 4-1-13 recorded services for Nutrition (daily breakfast, lunch and snack). Independent with Personal Care. Facility to provide transportation and activities. The NSA lacked review and if necessary revision at least once every 365 days. Interview on 7-15-15 at 1:15 pm with operator confirmed the NSA was not reviewed at least once every 365 days. For residents #101, #102, and #103, the operator failed to ensure the review and , if necessary, the revision of each negotiated service agreement at least once every 365 days.	S2120		